DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-01

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 0 2 9

2. STATE: Geor

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 441.55

7. FEDERAL BUDGET IMPACT:
a. FFY '01 $ 3,776,684
b. FFY '02 $ 5,106,738

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B pp.3g, 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B pp.3g, 4

10. SUBJECT OF AMENDMENT:

PHYSICIAN SERVICES

11. GOVERNOR'S REVIEW *(Check One)*:

ERVICES - COMMUNITY BASED
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Mark Trail

14. TITLE: Acting Director, DMA

15. DATE SUBMITTED: September 26, 2001

16. RETURN TO:
Georgia Department of Community Health
Division of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, GA 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **September 26, 2001**

18. DATE APPROVED: **December 21, 2001**

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **July 1, 2001**

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: **Eugene A. Grasser**

22. TITLE: **Associate Regional Administrator**
Division of Medicaid and State Operations

23. REMARKS:

Instructions on Back

POLICY AND PROCEDURES FOR ESTABLISHING
PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

H. INDEPENDENT LABORATORY AND X-RAY SERVICES

Payments are made for specific authorized procedures on a statewide basis and are limited to the lower of:

(a) the actual charge for the procedure, or

(b) the statewide rate in effect on the date of service.
Reimbursement for laboratory services performed by an independent laboratory will not exceed the upper limit of payment established by Medicare for the same clinical laboratory test.

I. ORTHOTICS AND PROSTHETICS SERVICES

The maximum reimbursement amount for it5ems and services will not exceed rates established by the State Agency based upon the usual and customary charge for the items and services.

Effective for dates of service July 1, 1994 and after, a $3.00 recipient co-payment is required on Orthotics and Prosthetics services.

Pregnant women, recipients under twenty-one years of age, , nursing home residents, and hospice services are not required to pay a co-payment. Emergency services and family planning are also exempt from a co-payment.

J. PHYSICIAN SERVICES (Includes Physicians, Podiatrists, Optometrists and Psychologists)

Payments are made for specific authorized procedures on a statewide basis and are limited to the lower of:

(a) The actual charge for the services; or

(b) The statewide rate in effect on the date of services.

(c) If the recipient is referred in writing by the surgeon to an optometrist for post-cataract surgery follow-up care, the surgeon's fee will be reduced by an amount equal to the maximum allowable reimbursement for the post-cataract surgery follow-up care.

POLICY AND METHODS FOR ESTABLISHING
PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

J. **PHYSICIAN SERVICES** (Includes Physicians, Podiatrists, Optometrists and Psychologists)

Payments for certain services rendered in a hospital, outpatient, or Ambulatory Surgical Center setting which are normally performed in a physician's private office or clinic, are made on a statewide basis and are limited to the lower of:

(a) The actual charge for the service; or

(b) The statewide rate in effect with the appropriate site of service differential on the date of service..

Services that are primarily performed in office settings will be subject to a reimbursement reduction when performed in an inpatient, outpatient, emergency, or ambulatory surgical setting. The reduced reimbursement is calculated at 90% of the Resource Based Relative Value Scale (RBRVS) facility-setting rate as specified by the current Medicare Fee Schedule.

Payments to physicians for anesthesia services performed by the physician or the mid level providers supervised by the physician, are paid based on the calculated anesthesia formula in effect on the date of service.

The sum of Base Units plus Time Units plus Special Condition Units, if applicable, is multiplied times the conversion factor for anesthesia services. The conversion factor service dates beginning on or after January 1, 1992, is 16.00 for all geographic areas when filing modifier* AA or 78. For modifiers* QK and QY, the conversion factor is 5.58. Modifiers* QX and QZ conversion factors are 10.42 and 15.84, respectively.

If a CPT-4 procedure is non-covered, anesthesia for that service is also non-covered.

POLICY AMD NETJPDS FPR ESTABLISHING
PAMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

J. **PHYSICIAN SERVICE** (Includes Physicians, Podiatrists, Optometrists and Psychologists)(continued)

*Descriptions:

AA	Anesthesia services personally performed by an Anesthesiologist
QK	Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individual(s) [i.e., Certified Registered Nurse Anesthetists (CRNAs) or Physician Assistant Anesthesiology Assistants (PAAAs)] by an Anesthesiologist
QX	CRNA and PAAA performing anesthesia services under the direct supervision of an anesthesiologist
QY	Single (one) medically directed anesthesia service performed by an Anesthesiologist
QZ	Non-medically directed CRNAs
78	Return trip to the operating room